



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CHRONIC PAIN RECOVERY CENTER
25810 OAK RIDGE DRIVE
THE WOODLANDS TEXAS 77380

Respondent Name

ACE AMERICAN INSURANCE CO

Carrier's Austin Representative Box

Box Number 15

MFDR Tracking Number

M4-10-1326-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Requestor notes that the carrier's reduction is based upon contractual agreement. However, the Requestor is not currently, nor has it in the past become a party to such agreement."

Amount in Dispute: \$875.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Respondent was notified of the of the request for medical fee dispute resolution on January 15, 2010; however, a response was not received.

Response Submitted by: N/A

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 03, 2009 thru February 13, 2009	97799-CP-CA	\$875.00	\$ 875.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. Texas Labor Code §413.011(d-1) sets out the requirement for carriers to provide copies of contracts.
3. 28 Texas Administrative Code §134.204 set out the reimbursement for Medical Fee Guideline for Workers' Compensation specific codes, services, and programs provided on or after March 1, 2008.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated February 26, 2009, March 10, 2009, March 19, 2009, June 19, 2009

- 150 – Payer deems the information submitted does not support the level of service
- (900-030) CV: This charge was reviewed through the clinical validation program
- 45 – Charge exceeds fee schedule maximum allowable or contracted/legislated fee arrangement.
- (100) Any network reduction is in accordance with the network referenced above.
- (113-001) Network import re-pricing – contracted provider
- W1 – Workers Compensation state fee schedule adjustment
- (663) Reimbursement has been calculated according to state fee guidelines
- A1 Claim service denied
- (942-003) Body part mismatch
- (905-005) The documentation attached supports treatment to the workers compensation injury. Correction of a data entry error has been made and we arrived to the same recommended allowance.

Issues

1. Did the requestor have a contracted/legislated fee arrangement?
2. Does the submitted documentation support the services billed?
3. Is the requestor entitled to additional reimbursement?

Findings

1. According to the Explanation of Benefits, the services in dispute were paid using a contracted fee arrangement. Texas labor Code §413.011(d-3) states that the Division may request copies of each contract under which fees are being paid, and goes on to state that the insurance carrier may be required to pay fees in accordance with the Division's Fee Guidelines if the contract is not provided in a timely manner to the Division. On August 03, 2010, the Division requested a copy of the contract between the informal/voluntary network and the requestor. The Division also requested documentation to support that the requestor was notified in accordance with 28 Texas Administrative code §133.4. The respondent failed to provide a copy of the requested documentation. For that reason, the disputed health care will be reviewed in accordance with §134.204.
2. Review of the submitted documentation supports the services were rendered as billed, and are therefore payable under 28 Texas Administrative code 134.204(h)(5).
3. Reimbursement for a CARF accredited facility is reimbursed at \$125.00 per hour in accordance with 28 Texas Administrative Code §134.204(h)(5). The requestor billed 8 hours for 8 dates of service and 6 hours for 1 date of service. The MAR amount is $\$125.00 \times 8 \text{ hours (per day)} = \$1,000.00 \times 8 \text{ (DOS)} = \$8,000.00$. The MAR amount for 6 hours for 1 DOS is \$750.00. Therefore, the total MAR for the disputed dates of service is \$8,750.00. The respondent reimbursed \$7,875.00 leaving an additional amount of \$875.00 due to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$875.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$875.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature

Pat DeVries
Medical Fee Dispute Resolution Officer

October 20, 2011
Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.